2/21/06

RHODE ISLAND DEPARTMENT OF HEALTH
FAMILY PLANNING HIV CTR FORM

1. Client Number: _____ 2. Project Number: _____ 3. Site Number: _____

4. Date of This Visit: _____

CLIENT DEMOGRAPHIC INFORMATION

5. Sex: _____MALE _____FEMALE

6. Health Insurance Provider:
- _____NONE
- _____SELF
- _____PUBLIC ASSISTANCE
- _____MILITARY/VA
- _____EMPLOYER

7. Age: _____

8. Ethnicity:
- _____ HISPANIC/LATINO
- _____ NOT HISPANIC/LATINO

9. Race (Check all that apply):
- _____WHITE
- _____BLACK
- _____ASIAN
- _____AMERICAN INDIAN/ALASKA NATIVE
- _____NAT HAWAIIAN/OTHER PACIFIC ISL

10. Zip Code: _____

PRE-TEST COUNSELING INFORMATION

11. Reason for Visit (Choose One or More):
- _____SYMPTOMATIC FOR HIV/AIDS
- _____CLIENT REFERRAL
- _____PROVIDER REFERRAL
- _____STD RELATED
- _____DRUG TRMT RELATED
- _____FAMILY PLANNING RELATED
- _____PRENATAL/OB RELATED
- _____TB RELATED
- _____COURT ORDERED
- _____IMMIGRATION/TRAVEL REQ.
- _____OCCUPATIONAL EXPOSURE
- _____RETEST
- _____REQUESTING HIV TEST
- _____ANNUAL VISIT
- _____OTHER

12. Since 1978 (Choose One or More)
- _____SEX WITH MALE
- _____SEX WITH FEMALE
- _____USED INJECTING DRUGS
- _____SEX WHILE USING NON-INJ DRUG
- _____SEX FOR DRUGS/MONEY
- _____STD DIAGNOSIS

13a. Sexual Relations With (Choose One or More):
- _____IDU
- _____MAN WHO HAD SEX WITH A MAN
- _____PERSON WITH HIV/AIDS
- _____PERSON WITH OTHER HIV/AIDS RISK

13b. Are/Were You (Choose one or more):
- _____BORN TO A WOMAN WITH HIV/AIDS
- _____ A HEMOPHILIAC/BLOOD RECIPIENT
- _____ EXPOSED TO HIV AT WORK
- _____ A VICTIM OF SEXUAL ASSAULT
- _____ NO ACKNOWLEDGED RISK

TESTING INFORMATION

14. Client Previously Tested?
- _____NO
- _____YES, NEGATIVE
- _____YES, POSITIVE
- _____YES, INCONCLUSIVE
- _____YES, UNKNOWN

15. If Tested This Visit, Indicate Type:
- _____CONFIDENTIAL STANDARD
- _____ANONYMOUS STANDARD
- _____CONFIDENTIAL RAPID
- _____ANONYMOUS RAPID
- _____**CLIENT NOT TESTED THIS VISIT**

16. **If Not Tested This Visit, Indicate Reason**:
- _____CLIENT DECLINED
- _____REFERRED ELSEWHERE
- _____PREVIOUSLY NEGATIVE
- _____PREVIOUSLY POSITIVE
- _____OTHER

------ STOP HERE IF CLIENT WAS NOT TESTED ------

17. Test result this Visit:
- _____NEGATIVE
- _____POSITIVE (Also choose one below if Rapid Test)
  - _____POSITIVE RAPID CONFIRMED POSITIVE
  - _____POSITIVE RAPID CONFIRMED NEGATIVE
- _____INCONCLUSIVE
- _____NO RESULT

DO NOT COMPLETE THIS SECTION IF CLIENT WAS NOT TESTED

POST-TEST COUNSELING INFORMATION

18. Client Post-test Counseled?
- _____NO
- _____YES, REQUESTED RESULT
- _____YES, WITH FOLLOW-UP
- _____YES, AT NEW CLINIC _____YES, OTHER

19. Date of post-test counseling: _____

20. If positive, referral to (check all that apply):
_____HIV MEDICAL CARE _____MENTAL HEALTH
_____DRUG TRMT _____OTHER